

How to Supercharge Your Brain

rd.com

Reader's Digest

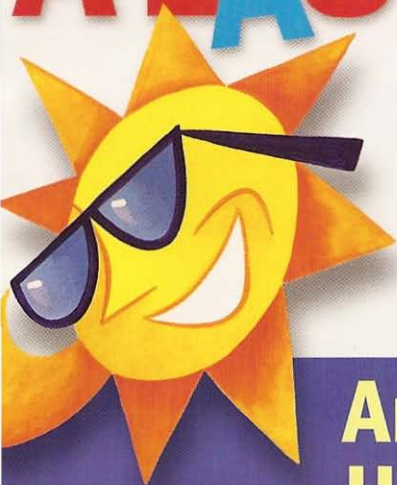


Lucy

Her passion,
love, and
heartbreak

PAGE 160

NEED A LAUGH?



50 Best Jokes

How Laughter Heals

What's Funny Now

PAGE 62

September
2003 \$2.99

PAGE 84

America's Biggest Health Care Crisis

PLUS Calculate What Your Time Is Worth
■ The Oddest Jobs ■ Everyday Toll of Driving
Deadly Secrets: Murder on Lost Dog Trail



FRIENDS OF Michael Hurewitz knew him as a man who would go out of his way to help others. So when his younger brother, Adam, needed a liver transplant due to a rare disease called sclerosing cholangitis, no one was surprised that Mike stepped forward.

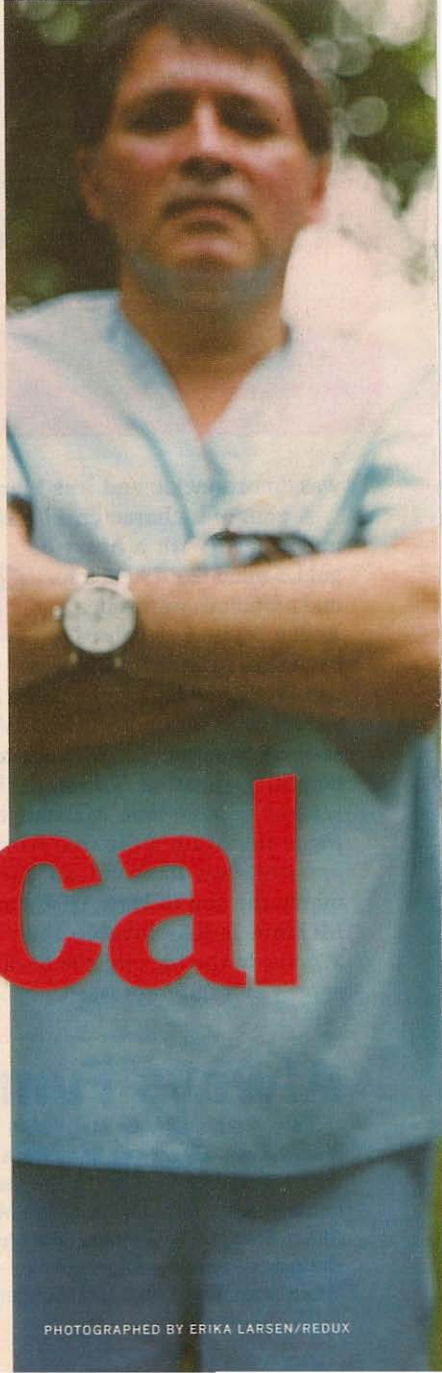
"He had worried about Adam's illness for years," says Mike's wife, Victoria. "This was a completely emotional decision." A 57-year-old reporter for the *Times Union* in Albany, N.Y., Hurewitz seldom spoke to his wife about the surgical risks he faced, and masked his own anxiety with humor.

In early 2002, both brothers entered Mount Sinai Medical Center in New York City, a world leader in living-donor liver

Condition: **Critical**

With nurses leaving in droves, a stay at the hospital **gets scarier every day**

BY JOHN PEKKANEN





At hospitals across the country, nurses are saying, "Enough!"

transplants. Unknown to them, however, nurses on that unit had been filing "protest of assignment" forms for months with the hospital administration and the New York State Nurses Association. Too few nurses, they claimed, were on duty to care for the patients.

Surgery for both brothers took place on Thursday, January 10, and went smoothly. Adam's healing progressed without a hitch, and today his new liver is functioning perfectly. But

attention. He also became chilled, so Victoria tracked down a nurse who told her they had no blankets. Victoria walked to her hotel room to get one.

By Sunday afternoon, Mike had begun coughing up blood and Victoria became more and more alarmed.

When a nurse appeared briefly in his room, Victoria's sister-in-law, a physician, asked her a question about Mike's blood test. "I don't know," the nurse replied curtly. "I've got three things going on right now." Another

The harried nurses paid scant attention as his heartbeat jumped and blood pressure dropped.

his brother's fate was far different.

At no time after his operation did Mike's surgeon pay him a visit. Instead, he was assigned to a first-year resident, who seldom appeared.

So Mike's nursing care was especially critical. It proved woefully inadequate. When Mike was moved into his regular hospital room 12 hours after surgery, his wife noticed that there seemed to be very few nurses on his floor. "When Mike needed his bandages changed, I'd have to chase a nurse down," she says.

A fit jogger and mountain climber, Mike appeared at first to be recovering uneventfully. But two days after surgery, monitors showed that he had an abnormally rapid heartbeat, and that his blood pressure had dropped. After giving him a shot for his symptoms, the harried nurses paid scant

nurse said she'd call a doctor, but the resident on call didn't stop by until 25 minutes later.

Mike vomited up blood for two more hours until, to Victoria's horror, he choked to death right in front of her. An autopsy revealed that Mike had been suffering from a serious and untreated bacterial infection.

Not long after Mike Hurewitz's death, Mount Sinai voluntarily suspended its living-donor liver transplant program for nearly a year. That wasn't enough for the New York State Health Department, which in August cited "serious quality care violations" not only regarding Mike Hurewitz, but in ten other cases. Mount Sinai was fined a total of \$66,000.

The health department's report bluntly stated that Mount Sinai did not provide adequate nursing staff.

Moreover, health officials found “no evidence,” in some cases, that nurses on the liver transplant unit provided follow-up care “to patients experiencing significant changes in their health condition.”

Victoria Hurewitz expresses her anger in plainer English: “Mike had space-age surgery and Third World care.” She filed a wrongful-death lawsuit that is now pending.

If only Mount Sinai were the exception. But across the country, hospitals are in the grip of a nationwide nursing shortage that promises to grow even worse. In a 2001 study by the SEIU Nurse Alliance, a national nursing union, two-thirds of RNs reported there are too few nurses in their hospital to provide high-quality care. Nearly all experts agree this shortage could soon become severe enough to cripple our entire health care system—and lead to more preventable deaths. “It’s going to hit us hard,” says Peter Buerhaus, senior associate dean for research at the Vanderbilt University School of Nursing, “and it’s just around the corner.”

AMERICA HAS FACED SOME nursing shortages before, two of the worst stretches being in the early and late 1980s. Yet the one unfolding now is “much more severe and long-term than those of the past,” according to Gary Mecklenburg, president and CEO of Northwestern Memorial Health-Care, a 750-bed hospital in Chicago.



Victoria Hurewitz is enraged that nurses barely looked in on her husband, even as he grew critically ill.

Managed-care companies helped kick off the shortage by cutting tens of thousands of nursing jobs in the mid-1990s to trim costs. Now this shortage threatens to become far worse due to simple demographics. First, the nursing work force is aging rapidly. Between 1983 and 2000, the number of registered nurses under age 30 dropped 41 percent, compared to a drop of only 1 percent in the entire American work force. Today, the average age of RNs is 43. Tens of thousands of them will be retiring in the next few years, and the U.S. Bureau of Labor Statistics estimates that by 2010—just seven years from now—more than one million new nurses will be needed.



Long hours and fewer nurses take a toll on RNs like Julie Semente of New York City. "I can't afford to risk my health, or my patients' lives," she says.

Now consider the aging baby boomers. They will start turning 65 in 2011, and by 2020, tens of millions of them will be in their 60s and 70s. Even as they deluge the health care system, the shortage of nurses is predicted to grow to 200,000 by 2010 and 400,000 by 2020.

Dr. Dennis O'Leary, president of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), says, "If nothing intervenes, the whole system could melt down." In the worst case, some hospitals will shut down whole units, people will experience longer waits for elective surgeries, and a growing number of patients will suf-

fer needless complications and deaths.

Why can't hospitals simply add staff to prevent this scenario? There's a far more intractable problem than costs: a deepening crisis of morale in nursing. According to a 1999 survey conducted by the University of Pennsylvania School of Nursing, 40 percent of hospital RNs say they are "dissatisfied" with their job. That's four times the average rate for American workers. It gets worse. A recent study of 10,184 nurses published in the *Journal of the American Medical Association* found that one in five nurses said they would quit the profession within a year.

Their grievances are rarely about the paycheck. Instead, they complain chiefly about the job stresses and the environment in hospitals today, according to Barbara Blakeney, president of the American Nurses Association. Hospitals didn't help matters when they began requiring RNs to work overtime to fill staffing gaps, leading to shifts of 16 hours or more. In one national survey, more than two-thirds of registered nurses reported working some kind of mandatory or unplanned overtime every month. On average, nurses work an extra eight and a half weeks of overtime a year.

"We are being put in situations where we are set up to fail," says Julie Semente, 45, an RN from Staten Island, New York. "After a 12-hour shift, you can't see straight. You stand there looking at this medication sheet and then at the patient and you're saying,

'May God help me. Please don't let me make a mistake with a decimal point.'"

Cheryl Johnson, a registered nurse at the University of Michigan Hospital in Ann Arbor, remembers driving home after a 12-hour shift, wondering why a patient suffering an allergic reaction to a bee sting had such a worrisome response to the epinephrine she gave him. Suddenly it hit her. She'd given him a larger dose than ordered.

"It had been in my 11th hour on duty," Johnson says. "I was tired."

Driving home, it suddenly hit her: **She'd given the patient a larger dose than ordered.**

Once home, she phoned the hospital to report her error. The patient escaped serious harm, but an overdose of the stimulant could have triggered life-threatening heart arrhythmias.

Medication errors clearly become more frequent when nurses are too rushed or too tired from long hours on the job. In the 2001 survey by the SEIU Nurse Alliance, 34 percent of the nurses reported that missed or delayed medication administration occurred at least once a week on their shifts, and another 8 percent reported that patients were given the wrong medication or dosage at least once a week.

To the risks from overwork and fatigue, add this problem: Even as managed care has thinned the ranks of RNs, it has cut costs by pushing patients out of the hospital as quickly as possible, leaving only the sickest be-

hind. So not only are fewer RNs spending longer hours caring for patients, these patients are more critically ill than in the past.

When 43-year-old Gary Stephens* was working in neonatal care in a Washington, D.C., area hospital, he believed his unit was becoming dangerously short-staffed. One Saturday he and his nurse partner were told to care for three-day-old Baby Kevin,* who suffered from a life-threatening bacterial infection. At the same time,

Stephens and his partner were assigned care of two-day-old Baby Anna,* born three-and-a-half months premature and clinging to life.

Baby Kevin's only hope for survival had been a machine called ECMO (extracorporeal membrane oxygenation), which would take over for his failing heart and lungs and buy the infant time to heal.

Because ECMO babies can deteriorate rapidly, Stephens's unit had always assigned two specially trained nurses for each infant on the ECMO machine. One would constantly watch the baby's vital signs while the other monitored the ECMO for potentially lethal bubbles or clots in the tubes that are circulating the baby's blood. All the while, they both had to con-

*Names changed to protect privacy.

tinually fine-tune the medications.

Baby Anna needed the same kind of constant monitoring, however, and taking care of these two critically ill babies at the same time was "an impossible assignment," Stephens says.

Within a day, Baby Anna developed a severe intestinal infection that forced surgeons to remove a section of her bowel. This was followed by a long period of antibiotic therapy and additional months in the hospital. (Both babies ultimately survived.)

"I believe if we had been able to watch Baby Anna more closely, we'd have caught the first subtle signs of her infection," Stephens says. "We might have headed off the worst of it."

Stephens protested the shortage of nurses to hospital management and never felt he got a satisfactory reply. About six months later, he was laid off in a round of nursing cutbacks.

THE SINGLE MOST unnerving scenario for nurses is encapsulated in an opaque hospital euphemism: "sentinel event." In layman's terms, a sentinel event refers to an unanticipated death, injury or permanent loss of function while under hospital care.

In August 2002, the JCAHO tied the shortage of RNs to one-quarter of the 1,600 sentinel events reported by hospitals between January 1996 and March 2000. (Experts think sentinel events are underreported and that the actual number is significantly higher.)

Last year, a research team led by

Linda Aiken of the University of Pennsylvania School of Nursing examined the outcomes of 232,342 relatively common operations, from appendectomies to orthopedic procedures. Their study found that when hospitals exceed a ratio of four surgical patients to one nurse—as many do—the risk of death increases by 7 percent for each additional patient. So if a nurse who is assigned four patients has to start caring for six, the risk of death for all her patients jumps by 14 percent. If the patient-to-nurse ratio increases to eight to one, the risk of death jumps 31 percent.

"Of the hospitals we looked at," Aiken says, "88 percent had patient-to-nurse ratios greater than four to one." Only 12 percent had four patients or fewer per nurse.

At the time of Mike Hurewitz's death, the patient-to-nurse ratio in Mount Sinai's liver transplant unit was seven to one, according to New York State. At Wesley Medical Center, a large for-profit hospital in Wichita, Kan., one RN sometimes cared for up to 15 patients, according to court records. This may have contributed to the death of 38-year-old Deedra Tolson, who underwent a routine hysterectomy at Wesley in 1997. After surgery, Tolson, mother of a two-year-old boy, experienced a steady drop in blood pressure and urine output, both signs that she was bleeding internally. But nurses were too busy to check on her, says Brad Prochaska, the attorney who brought suit on behalf of Deedra's husband, Craig. Tolson slipped into a

Take Control of Your Care

WITHOUT NURSES TO DEPEND ON, patients need by their bedsides a family member or friend who will press for the best possible treatment. But there are other smart things to do **before** entering a hospital:

1. Find out the RN-to-patient ratio.

If it's greater than 1 to 4, you may get sub-par care. In intensive care units, the ideal ratio should be 1 to 2.

2. Check also the ratio of RNs to LPNs.

Licensed practical nurses aren't always skilled in all the procedures performed by RNs, such as administering powerful IV medications. Fewer than 4 RNs to every 1

LPN may be a red flag.

3. Study the report card.

This past fall, three heavyweights in health care—the American Hospital Association, the Federation of American Hospitals, and the Association of American Medical Colleges—launched a program to rate the quality of hospitals. These assessments are based on the treatment of three common but serious medical con-

ditions: heart attack, congestive heart failure and pneumonia. Hospitals participate voluntarily, but so far 1,000 of them are being appraised. The results will be posted at cms.gov.

4. Locate the nearest magnet.

If you can easily check into a magnet hospital, you'd be foolish not to. To see the full list, with locations, go to nursingworld.org/ancc/magnet/magnet2.htm.

coma and died four days after surgery. In 1999, the hospital agreed to pay nearly \$1 million to settle the case (although it never admitted fault).

GIVEN THE PRESSURES and anxieties within the profession today, it is no surprise that the nurse pipeline is drying up. Between 1995 and 2001, the number of nursing candidates taking the U.S. national licensing exam fell 28.7 percent. A 2002 survey found that only 4.5 percent of female college freshmen, and less than 1 percent of male freshmen, plan to become nurses.

One student who did intend to go into nursing was Jessica Young, 24, who came within a year of completing her RN course work at the University

of Maryland, Baltimore. But she became discouraged, in part because she spent time in a hospital observing nurses on the job. "I saw how short-staffed they were," Young says. "They were just running all the time." Young decided to drop out of her RN training program and got a degree in health management instead. Today she works for a pharmaceutical firm.

The fact that not enough young people are replacing the nurses who are retiring or quitting helps explain why, nationally, 126,000 hospital nursing positions—12 percent of the total—remain unfilled.

WHILE NO ONE HAS a surefire cure for this nursing crisis, some pin their

hopes on new medical technologies. Already, in patients' rooms and at nurses stations, digital monitors give constant readouts of vital signs such as heart rate, EKG tracings and blood pressure—sparing nurses a lot of time-consuming work at the patient's bedside.

Other technologies now enable patients to administer their own intra-

logy is that, even as it eases the nursing burden, it adds to it.

In any case, technology can never fill all the critical roles that nurses play. For instance, every time a nurse enters a patient's room, she observes his or her color, demeanor, state of mind and speech. Any subtle change can signal trouble. Mike Hurewitz failed to get this sort of assessment—

The nurse pipeline is drying up. Nationally, 126,000 hospital nursing positions remain unfilled.

venous pain medication with the touch of a button (calibrated to prevent overdoses). Computer bar codes, similar to those imprinted on supermarket items, are starting to be used to safely and accurately match patients with their prescribed medication.

Then there are new procedures such as laparoscopic surgery, which have revolutionized operations, sharply cutting the need for longer hospital stays. Some patients who once remained in the hospital four or five days are now able to leave within 24 hours, thanks to these faster and less invasive procedures.

But medical technology won't likely prove a panacea. For one thing, these technologies still need people, often nurses, to monitor them. Also, technical advances are keeping people alive longer than in the past—a good thing, of course, but it extends their need for nursing care. So the irony of ever-improving medical technol-

ogy is that, even as it eases the nursing burden, it adds to it.

Perhaps the real answer to the nursing shortage won't come from investing in technology but from investing more in our nurses. That's the goal of a program launched by the American Nurses Association that grants "magnet" status to hospitals that can prove two things: They provide high-quality nursing care and they retain their nurses. Earning the magnet designation is one way hospitals can boost their prestige and thereby attract more patients. It's also so tough to attain that only 74 of the country's 4,908 community hospitals have achieved this status.

Among the qualifying criteria for hospitals: authority given nurses to make major health care decisions; opportunities for nurses to further their education; investment in technologies that nurses identify as useful; and fair compensation.

Often, magnet hospitals provide extra services to help their nurses cope with job pressures. North Shore Long Island Jewish Health System, several magnet hospitals that employ more than 7,000 nurses, takes care of its time-pressed nurses by offering such things as online banking, a dry cleaning service and a food shopping service that delivers groceries to them at work. The hospital's nursing turnover is only 5 to 6 percent a year, about a quarter of the current U.S. average.

In fact, some magnet hospitals have waiting lists of applicants. Meanwhile, studies show that patients in these magnet hospitals have lower mortality rates. They also have shorter lengths of stay, which offsets the costs of the higher nurse-to-patient ratio.

UNFORTUNATELY, no one can count on living near a magnet hospital. As the nursing crisis builds, the smartest response may be something patients' families can do.

When her husband underwent surgery, Karen Chase, an RN in Westwood, N.J., virtually moved into his hospital room. Chase knew exactly what patients are up against: She once worked in a hospital, but is now a private duty nurse.

At one point, as her husband moved from his bed to a chair, a spinal catheter that administered his pain medication slipped out. "This catheter should be sterile, and it was dangling on the floor," Chase says. She watched in disbelief as a nurse's aide started to stick the catheter back in.

"What are you doing?" Chase screamed. "You can't reattach that. It's dirty!"

If Chase hadn't been camped out in the room, she wouldn't have caught the mistake. Most frustrating to her, she knows that any RN would have known what to do. But there were no nurses around.

Next month: "One Day in Critical Care: A Nurse's Story."

CAN YOU HEAR ME NOW?

Once, in the middle of Jay Leno's monologue, a cell phone rang in the audience. Jay didn't get angry, and he didn't have the person evicted; that's not his style.

Instead, he walked into the crowd and right there on national television, he said, "Here, let me talk to your friend."

He answered the woman's phone, saying, "This is Jay Leno. I'm in the middle of my monologue right now, so is there a message I can take?"

JON MACKS. *How to Be Funny* (Simon & Schuster)

